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THE BRITISH COLUMBIA CORONERS SERVICE

Mandate

The British Columbia Coroners Service is responsible by statute (*Coroners Act*) for the investigation and certification of all unnatural, sudden and unexpected, unexplained or unattended deaths. The Coroners Service is a fact-finding, not a fault-finding, agency. It makes recommendations to improve public safety and prevent deaths in similar circumstances.

Historic Development

The office of the coroner is one of the oldest common law institutions, with references dating as far back as the time of Saxon King Alfred in 925 A.D. The first detailed statute concerning coroners was the *Statute of Westminster* of 1275. The coroner was known as a "Keeper of the pleas of the Crown" or "Crowner" from which the term "coroner" evolved.

The former utility of the coroner as a protector of Crown revenue, or as an agency for bringing suspects to trial, is no longer a consideration. However, what does remain constant in the face of this evolution is the continuing concern with the fact of death and the unchanged interest of the public in the protection of its members. The death of a member of society is a public fact. The circumstances that surrounded that death and whether it could have been avoided are matters of interest to all members of the community. In this sense, the coroner exists to provide a truly public service, both individually and collectively.

Each province and territory in Canada operates its own sudden death inquiry system. Coroners are governed by the BC *Coroners Act* proclaimed in 1979.

Organizational Structure

The Coroners Service is an independent agency, falling under the Ministry of Public Safety and Solicitor General for administrative and budget purposes. The Chief Coroner, located in Burnaby, supervises the Coroners Service. There are a total of five regional offices, with one in each of the following cities: Victoria, Vancouver, Surrey, Kelowna, and Prince George. Each of these offices is led by a Regional Coroner.

In 2002, the Coroners Service had 35 full-time employees, with 11 of these functioning as full-time coroners. There were approximately 86 appointed community coroners who provided services to local and sometimes remote communities.

Responsibilities

The responsibilities and functions of the BC Coroners Service include:

1. Ascertaining and clarifying the facts of all unexpected and unnatural deaths in BC to determine the identity of the deceased, and how, when, where, and by what means the deceased died;

2. Ensuring that no death is overlooked, concealed or ignored;

3. Producing a judicial, public document, either a Judgement of Inquiry or a Verdict at Coroner's Inquest, that reports on the findings of the coroner's investigation. These documents form the official record of the identity of the deceased and how, when, and where he or she died. The medical cause of death and classification are noted. This serves the general public interest and

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adds to the sum of knowledge in the fields of forensic science, epidemiology, public safety, and public health;

4. Making recommendations, where appropriate and feasible, to both public and private agencies, so that a similar death is less likely to occur in the future. The prevention of death forms a critical part of the overall mandate of the BC Coroners Service;

5. Conducting inquests (quasi-judicial court proceedings) when mandated by the *Coroners Act* or when there is a strong public interest in the circumstances of the death or potential for prevention of death in similar future circumstances. An inquest publicly presents all evidence relating to the death, focuses community attention, and often makes recommendations which may help prevent future deaths;

6. Collecting death information, statistical analysis, and research materials;

7. Developing in-depth position papers about frequently recurring incidents in an effort to prevent further deaths from a particular specific cause or failing.

The Coroners Service has three major program areas: investigative, judicial, and preventative.

INVESTIGATIVE

Coroners require a careful examination of the circumstances leading up to a death to understand why the individual died. Pathologists, toxicologists, forensic investigators, and medical investigators may be used to provide assistance.

Pathology

In deciding whether or not an autopsy is required, the coroner must deem it necessary in order to determine the cause and manner of death. The autopsy must be considered to be in the public interest. In general, if a reasonable and probable cause can be deduced on the basis of the decedent's medical history, the circumstances surrounding a death and a careful examination of the body, an autopsy may not be necessary for the coroner's mandate.

There is a great difference between a hospital autopsy and a forensic autopsy. Hospital autopsies are directed towards substantiating the accuracy of a diagnosis and therapy instituted during the course of an illness as well as determining the immediate cause of death.

The forensic autopsy is a specialized autopsy. The coroner authorizes a forensic, or medico-legal, autopsy to determine the cause of death where it cannot otherwise be determined; to collect evidence from the body; to document findings useful in clarifying time and circumstances of death; and, finally, to obtain evidence aiding in the identification of the body.

In British Columbia, the Coroners Service retains the services of pathologists who conduct medico-legal autopsies on a fee-for-service basis.

In 2002, the Coroners Service ordered 1,888 autopsies, with 1620 full autopsies and 268 external autopsies. Together, these represent approximately 27 per cent of all cases reported to the Coroners Service in 2002.

Toxicology

Coroners authorize toxicology testing when it is required to establish or confirm the cause and manner of death. For the most part, toxicology

testing is provided on a fee-for-service basis at the Provincial Toxicology Centre, an accredited laboratory, located at Riverview Hospital in Port Coquitlam, BC. In cases also under criminal investigation, the RCMP Crime Laboratory conducts toxicology testing. Some toxicology testing is performed at regional hospitals. In 2002, 1810 toxicology tests were ordered by the Coroners Service.

Training & Forensics

This section of the BC Coroners Service has three core responsibilities: training, mass fatality incident planning, and forensic services. With respect to the first of these three responsibilities, the Manager of Training and Forensic Services is in charge of the development and maintenance of the BC Coroners Service Training Framework, under which the annual basic training course for coroners takes place. With the development of the agency's new database, this Manager will also be responsible for facilitating the required technological training of managers and subsequently of coroners. Secondly, consistent with the agency's mandate to investigate *all* sudden and unexpected deaths, the manager is responsible for facilitating the agency's recovery, identification and repatriation of all human remains in the event of a mass fatality incident. This is done with the help of the Disaster Team, which is made up of 10 members, most of whom are headquarters managers. Finally, once again consistent with the agency's responsibility to determine the identities of deceased persons who die of unnatural and unexpected causes, the Manager of Training and Forensic Services either directly provides or coordinates the delivery of forensic services for the purposes of identification in areas such as anthropology, osteology, odontology, and DNA.

Medical Investigations

When coroner cases involve complex medical facts, registered nurses are assigned to review medical charts and interview persons who cared for the deceased. They establish a chronology of events to identify concerns and make recommendations that may prevent future deaths. The medical investigator prepares a specialized summary investigative report for the coroner. In 2002, 42 coroner cases were referred to medical investigations.

JUDICIAL

A coroner's investigations may be concluded by one of two procedures: Judgement of Inquiry or Inquest.

Inquiry

The most common process is for the coroner to conduct an inquiry and prepare a report for the Chief Coroner as provided by Section 20 of the *Coroners Act*. A coroner's inquiry is a quasi-judicial process conducted without a jury. The coroner interviews witnesses, and reviews all investigative documents gathered from other agencies to determine the facts. The report outlines the facts of the death, determines the medical cause, and classifies the death as natural, accidental, suicide, homicide, or undetermined. Recommendations can be made to specific individuals and/or agencies, suggesting changes or improvements so that similar deaths or injuries can be prevented.

Inquest

An inquest is a quasi-judicial hearing held in an open forum where witnesses are subpoenaed to testify under oath before a jury of five persons. An inquest is not a forum to resolve civil disputes or to conduct prosecutions. An inquest is not a trial and a coroner is not a judge. The

proceedings are investigational as opposed to accusatory or adversarial. There is no "accused" or "defendant," and no "parties" or "lis."

There are several reasons to hold an inquest. The sections of the *Act* which outline the circumstances under which an inquest is held are:

- Section 10, which makes it mandatory to hold inquests into deaths of persons while in police custody;
- Section 18, which provides for the calling of an inquest when the coroner determines it to be "necessary;"
- Section 21, which states that a coroner conducting an inquiry may, for reasons specified in Section 21, change the inquiry to an inquest and summon a jury for that purpose.

Over time, these latter two sections have been generally interpreted to call for an inquest for the following reasons:

1. If there are general public concerns regarding the circumstances;
2. If a witness is refusing to provide evidence to a coroner conducting an inquiry;
3. And, finally, if agencies, institutions, or interest groups are legitimately pointing out concerns worthy of public attention.

The Attorney General may also, under special circumstances, direct an inquest be held as provided in Section 23 of the *Coroners Act*.

Inquest proceedings begin with the presiding coroner explaining the mandate to the jury and the jury's responsibilities under the *Coroners Act*. The coroner reviews applicable sections of the *Act* for the information of the jury and gives a short summary of facts relating to the death. Witnesses are then called and examined by coroner's counsel, the coroner, members of the jury, and persons "granted standing." Persons are given "standing" if their interests may be affected by evidence called. Persons with standing, or their representative, may participate fully in the inquest by asking questions and calling evidence. Once all the evidence has been given, the coroner adjourns the court and prepares a summation and overview of the evidence presented. The hearing is then reconvened and the summation is given to the jury. The jury prepares its verdict, which may be unanimous or by majority. The verdict and findings must not make any finding of legal responsibility or express any conclusion of law.

The *Coroners Act* provides no power to order change. The coroner, however, submits the jury's recommendations to the Chief Coroner for dissemination to appropriate persons, agencies, and ministries of governments. The jury recommendations must be lawful and are expected to be relevant and reasonable.

PREVENTATIVE

The Chief Coroner is responsible for bringing the findings and recommendations from coroner investigations and inquest juries to the attention of appropriate individuals, agencies, the public, and ministries of government to assist in improving public safety and in preventing similar deaths in the future.

The Coroners Service has no statutory authority to order change or to ensure that its recommendations will be carried out. However, this agency is generally successful in having most of its recommendations considered and acted upon. In 2002, the Coroners Service had a 67% response rate to its recommendations, with 66% of these responses being positive. As a direct result of coroner and jury recommendations, policies and procedures have been altered, more monitoring has occurred, and greater care and attention has been paid to conditions which might cause injury or death in the future. Through judicial recommendations,

public awareness, and statistical analysis and research, the preventative role is affected.

Coroner Recommendations

In 2002, BC coroners sent approximately 4,000 recommendations from inquests and coroner inquiries to private agencies, as well as agencies and ministries of government, addressing a variety of public safety issues. A summary of the Inquest recommendations and responses are included in the Inquest Statistics portion of this report.

Research

A variety of agencies use data from coroner files in a collective review of deaths in certain categories that can be useful in provincial and/or federal accident, suicide, and injury prevention strategies. These agencies are vetted by the Coroners Service and must sign a research agreement, which ensures security and confidentiality. Those agencies use coroner information in their own injury/death prevention strategies.

Red Cross

The Canadian Red Cross and The Royal Life Saving Society Canada have combined efforts to work with communities across BC and the Yukon to reduce the number of water-related fatalities and injuries. These agencies produce a joint provincial summary of drownings in BC and the Yukon. The coroner files provide the necessary data to allow these agencies to fulfil their role in educating the public, and reducing injuries and death due to drowning.

Traffic Injury Research Foundation

The Traffic Injury Research Foundation of Canada (TIRF) has used coroner files to compile data on alcohol-use related to motor vehicle fatalities since 1974. A fatality database is maintained for all provinces across Canada. This database provides a comprehensive source of objective data on alcohol use among persons fatally injured in motor vehicle accidents. This database provides a means of monitoring changes and trends and is a valuable tool for research on alcohol-impaired driving.

Underwater Council of British Columbia

The Underwater Council of British Columbia is dedicated to furthering safe diving practices. The Council undertakes to review all coroner diving files on a yearly basis to produce a Recreational Diving Fatalities report, which summarizes circumstances and recommendations on diving deaths. This report is an invaluable reference for scuba instructors, educators and concerned scuba enthusiasts.

Canadian Agricultural Injury Surveillance Program

The Canadian Agricultural Injury Surveillance Program collects and interprets information on agricultural injury across Canada. This agency reviews all cases identified by the coroner as 'farm' related and abstract data from the files. The results are combined with data from other provinces to form the National Registry of Farm Fatalities. A final report is produced which summarizes risks, trends, and other patterns among farm fatalities and provides farm safety specialists with an objective basis to develop and target farm safety programs in BC.

Coroners Act & Notification Requirement

Section 9 of the *Coroners Act* states the requirement for reporting a death to the coroner. This section of the *Act* requires that a person shall immediately notify a coroner or a peace

officer of the facts and circumstances relating to a death where he/she has reason to believe that a person has died under circumstances where an investigation may be required. The *Act* specifically requires the reporting of violent, unexplained or sudden/unexpected deaths; deaths in custody; and deaths of persons to whom the *Mental Health Act* applies.

The Coroners Service is responsible for the investigation of all reported deaths to determine the identity of the deceased and the facts as to when, where, and by what means the deceased came to his/her death.

The scope of the coroner's investigation has broadened over the years. Previously, the major emphasis was directed towards the investigation of the actual medical cause of death to the exclusion of practically all other aspects. Now, the medical cause of death is only one of many factors to be considered. The non-medical factors causing death are often equally important.

When a death is reported, the coroner focuses on who the deceased was and when, where, and by what means death occurred. The coroner has extensive authority to collect information, conduct interviews and seize documents or other materials. The coroner may also use information received from other agencies, such as the Workers' Compensation Board in industrial related deaths, or from the local police regarding deaths that may be crime related. The coroner and the police will work closely together when crime is a factor in a reported death.

Statistical Summary of Deaths

Statistical Reporting

The Coroners Case Management System, CCMS, is an on-line Oracle database that maintains information on all reported deaths in British Columbia. The database contains information that is critical to death prevention efforts.

CCMS was developed in 1992 to assist in tracking and summarizing case information, and is utilized for two main purposes: to facilitate enquiries and to allow for the statistical reporting of deaths. This statistical reporting allows the Coroners Service to identify problem areas relating to causal factors and to correlate evidence to support recommendations to prevent future deaths. This statistical reporting is accomplished by the use of a coding system, which is based on definitions adopted from the World Health Organization's International Classification of Diseases.

Cause of Death Codes

The primary definitions consist of the CAUSE OF DEATH and the MEANS OF DEATH:

"CAUSES OF DEATH are all those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced the injuries."

The " UNDERLYING CAUSE OF DEATH OR MEANS OF DEATH is (a) the disease or injury which initiated the train of events leading directly to death or (b) the circumstances of the accident or violence which produced the fatal injury."

It is vital to capture the precipitating event or Means of Death to provide researchers working on death prevention with meaningful research data.

Vital Statistics

The *Vital Statistics Act* requires that a coroner or physician provide a Medical Certificate of Death for each death in British Columbia. The certificate is filed with a District Registrar of

Births, Deaths & Marriages within 48 hours of the death. The funeral director, or person acting as such, is required to complete the Registration of Death, collect the Medical Certificate of Death and file both with the District Registrar. If the cause of death cannot be determined within the time required, the coroner provides a provisional certificate that is later updated with the appropriate cause of death information.
Besides requiring this information for official records, the Division of Vital Statistics Research Branch utilizes mortality data for various aspects of health planning and education. It provides valuable information to health care researchers, planners and providers alike.

Classifications of Death

As of October 1993, all deaths reported to and investigated by the Coroners Service have been classified, for statistical purposes, into the following five categories:

1. A **Natural** death is one primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors.

2. An **Accident** is a death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident.

3. A **Suicide** is a death resulting from self-inflicted injury, with intent to cause death.

4. A **Homicide** is a death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.

5. An **Undetermined** death is defined as one that, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide, or homicide.

The Coroners Service maintains a separate category, referred to as a **Non-coroner's Case**. A Non-coroner's Case is a natural death where none of the criteria of Section 9 of the *Coroners Act* are met. Following a brief investigation, the coroner may conclude the case if a doctor has signed the Medical Certificate of Death. The coroner may also sign the Medical Certificate of Death if he or she is satisfied that the death is natural and consistent with known medical history.

CASELOAD STATISTICS (2002)

Total Cases (2002)

Death Class	Total Cases
ACCIDENT	1,267
HOMICIDE	112
NATURAL	849
NON-CORONERS	4,163
SUICIDE	537
UNDETERMINED	112
Total	**7,040**

Regional Distribution (2002)

Region	Accident	Homicide	Natural	NonCoroner	Suicide	Undetermined
Fraser	267	44	169	1,115	154	26
Interior	372	15	229	868	107	24
Island	205	16	184	1,065	104	22
Metro	234	24	187	846	132	32
Northern	189	13	80	269	40	8
Total	**1,267**	**112**	**849**	**4,163**	**537**	**112**

Regional Caseload Review (1997 - 2002)

Region	2002	2001	2000 *	1999	1998	1997
Fraser	1,775	1,919	1,973	2,709	2,983	3,014
Interior	1,615	1,361	1,418	1,868	2,035	2,144
Island	1,596	1,443	1,364	1,866	1,868	1,855
Metro	1,455	1,279	1,259	1,887	2,053	1,941
Northern	599	525	578	676	695	625
Total	**7,040**	**6,527**	**6,592**	**9,006**	**9,634**	**9,579**

* - An amendment to the Coroner's Act in 2000, no longer requiring all deaths in Community Care Facilities to be reported to a coroner, has resulted in a decrease in the number of natural (expected) deaths reported to the Coroners Service

ACCIDENTAL DEATHS (2002)

Recreational	Cases
AIR	
Hang Glider	2
Other aircraft (AP/03	3
Skydiving/Parachuting	1
Ultra-light Aircraft	4
LAND	
Hiking/Climbing	9
Horseback Riding/Polo	1
Hunting	1
Mountain Biking ('99)	1
Skateboarding	1
Street Bike (No MVA)	1
Team Sports	2
MOTORIZED	
Dunebuggy	1
Motorbike/ATV/Offroad	1
Personal Water Craft	2
Power Boating	7
SNOW	
Heliskiing	3
Snowboarding	4
Snowmobiling	5
Snowskiing	7
WATER	
Canoe	2
Diving	1
Fishing	6
Innertube	1
Kayak	2
Rowboat	2
Scuba Diving	2
Swimming	15
Windsurfing	1
OTHER	
All other	13
Total	**101**

Occupational	Cases
Comm Hunt/Fish/Trap/Oth Vessel	8
Construction Site: Commercial	3
Construction Site: Residential	3
Construction Sites - other	2
Electrical/Powerlines	1
Excavating/Paving/Grading	1
Farm Worksite (March/95)	5
Forestry Sites	12
Helicopter Logging	4
Industrial	4
Industrial - Material Hand.	4
Mine, Quarry, or Oil/Gas	3
Other Place of Work	20
Policing - police officer	1
School/University	1
Total	**72**

Other Accidents	Cases
Motor Vehicle	461
Alcohol/Drug Poisoning	271
Fall	163
Other	84
Airway obstruction	28
Fire	27
Drowning *	20
Carbon Monoxide	13
Air Crash	8
Skytrain or Railway	7
Exposure	7
Firearms	3
Not yet determined	2
Total	**1,094**

* - Does not include drownings counted in the Recreational category, i.e., swimming

ACCIDENTAL MOTOR VEHICLE DEATHS (2002)

By Victim Type

Victim Type	Cases
Driver	223
Passenger	130
Commercial Truck Driver	13
Commercial Truck Passenger	2
Motorcycle - Moped	34
Pedestrian	47
Pedal Cyclist	6
MVA/Train	2
Other	4
Total	**461**

Regional Distribution

Victim Type	Fraser	Interior	Island	Metro	North
Driver	46	90	17	23	47
Passenger	33	52	14	10	21
Commercial Truck Driver	2	4	0	1	6
Commercial Truck Passenger	0	1	0	0	1
Motorcycle - Moped	10	9	4	4	7
Pedestrian	17	10	3	14	3
Pedal Cyclist	1	2	1	1	1
MVA/Train	0	2	0	0	0
Other	0	3	0	0	1
Total	**109**	**173**	**39**	**53**	**87**

CHILD DEATH REVIEW (Ages 0 - 18 yrs)

Total Cases Reported (1998 - 2002)

Death Class	2002	2001	2000	1999	1998
ACCIDENT	88	95	100	109	93
HOMICIDE	13	5	14	11	4
NATURAL	31	40	39	55	49
NON-CORONERS	29	27	36	46	45
SUICIDE	24	11	30	22	17
UNDETERMINED	26	15	7	9	13
Total	**211**	**193**	**226**	**252**	**221**

Age Distribution

Age Group	2002	2001	2000	1999	1998
0 to 11 months	59	48	54	76	68
1 to 4 years	20	23	19	29	28
5 to 9 years	18	20	12	16	21
10 to 14 years	37	24	25	35	27
15 to 18 years	77	78	116	96	77
Total	**211**	**193**	**226**	**252**	**221**

Accidental Child Deaths by Means of Death

Means of Death	2002	2001	2000	1999	1998
Motor Vehicle	47	41	60	69	53
Drowning	9	12	15	14	14
Alcohol / Drug Poisoning	4	5	4	3	4
Airway Obstruction	3	3	2	7	3
Fall	4	4	2	0	2
Fire	2	13	6	1	5
Air Crash	0	0	0	2	0
Exposure	1	2	1	1	1
Dirt Bike / ATV / Snowmobile	1	4	2	3	1
Other	17	11	8	9	10
Total	**88**	**95**	**100**	**109**	**93**

SUDDEN INFANT DEATH SYNDROME (SIDS)

SIDS Ten-Year Review (1993 - 2002)

Case Year *	Cases
1993	50
1994	40
1995	50
1996	25
1997	24
1998	16
1999	14
2000	9
2001	5
2002	13

* - Decreases in the number of SIDS deaths in recent years may be, at least in part, attributable to changes in how the SIDS cause of death has been applied. A case previously classified as Suddent Infant Death Syndrome (SUDS) may more recently be classified as Sudden Unexpected Death in Infancy (SUDI)

SIDS Regional Distribution

Region	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993
Fraser	5	1	6	4	4	8	9	14	16	12
Interior	3	0	0	2	4	2	2	9	5	7
Island	3	4	0	5	5	8	9	14	12	15
Metro	0	0	1	1	1	2	2	4	4	5
Northern	2	0	2	2	2	4	3	9	3	11
Total	**13**	**5**	**9**	**14**	**16**	**24**	**25**	**50**	**40**	**50**

SUICIDES

BC Suicide Rates per 100,000

Case Year	Cases	Rate per 100,000
2002	537	13.0
2001	470	11.5
2000	484	12.0
1999	498	12.4
1998	509	12.8
1997	583	14.8
1996	557	14.4
1995	534	14.1
1994	513	14.0
1993	492	13.8
1992	514	14.8
1991	489	14.5
1990	426	12.9
1989	489	15.3
1988	456	14.6
1987	459	15.0

BC Five-Year Suicide Review (1998 - 2002)

Age Category	2002	2001	2000	1999	1998
12 and under	2	0	0	0	0
13 - 19	29	15	35	23	22
20 - 29	71	55	84	68	74
30 - 39	97	99	94	107	107
40 - 49	131	116	105	113	131
50 - 59	101	95	72	88	77
60 - 69	51	43	42	40	42
70 - 79	37	28	31	36	31
80 and over	18	19	20	23	24
Age unknown	0	0	1	0	1
Total	**537**	**470**	**484**	**498**	**509**

BC Five-Year Suicide Review (cont'd)

Gender	2002	2001	2000	1999	1998
Female	132	107	124	102	117
Male	405	363	360	396	392
Total	**537**	**470**	**484**	**498**	**509**

Region	2002	2001	2000	1999	1998
Fraser	154	147	127	134	140
Interior	107	94	95	94	98
Island	104	81	110	110	117
Metro	132	110	110	109	113
Northern	40	38	42	51	41
Total	**537**	**470**	**484**	**498**	**509**

Suicides by Method of Death	2002	2001	2000	1999	1998
Hanging	167	123	149	152	139
Suffocation / Smothering / Other	13	8	14	17	16
Carbon Monoxide Poisoning	42	40	50	54	72
Drowning	31	20	24	16	21
Fall	37	35	37	27	24
Firearms	90	90	84	115	103
Stabbing / Incised Injuries	15	23	14	11	10
Alcohol / Drug Poisoning	114	111	89	83	111
Other Poisoning	6	6	4	9	2
Skytrain / Railway	2	6	7	6	5
Motor Vehicle Accident	7	1	5	7	3
Fire	3	4	1	0	1
Other	10	3	6	1	2
Total	**537**	**470**	**484**	**498**	**509**

ILLICIT DRUG DEATHS

These tables display the number of non-therapeutic (illicit) drug deaths in BC, where the cause of death was due to or a consequence of an illicit drug overdose. Illicit drugs include cocaine, herion and illicitly purchased methadone. These tables do not include cases in which illicit drugs may have contributed to, but were not the cause of death.

BC Illicit Drug Deaths

Year	Total	Year	Total	Year	Total
1988	39	1993	361	1998	417
1989	67	1994	317	1999	278
1990	82	1995	224	2000	248
1991	124	1996	312	2001	246
1992	164	1997	310	2002	170

REGION	2002	2001	2000	1999	1998
Fraser	47	74	78	91	104
Interior	23	25	24	15	36
Island	40	45	40	48	58
Metro	53	94	95	116	199
Northern	7	8	11	8	20
Yearly Total	**170**	**246**	**248**	**278**	**417**

GENDER	2002	2001	2000	1999	1998
Female	40	53	41	49	74
Male	130	193	207	229	343
Yearly Total	**170**	**246**	**248**	**278**	**417**

AGE	2002	2001	2000	1999	1998
20 and under	5	7	7	10	12
21 - 30	39	52	38	49	73
31 - 40	56	97	101	111	173
41 - 50	56	65	73	82	122
51 - 60	12	19	28	24	35
Over 60	2	6	1	2	2
Yearly Total	**170**	**246**	**248**	**278**	**417**

BC Illicit Drug Deaths cont'd

Region

	2002	2001	2000	1999	1998	1997
Fraser	47	74	78	91	104	90
Interior	23	25	24	15	36	17
Island	40	45	40	48	58	43
Metro	53	94	95	116	199	148
Northern	7	8	11	8	20	12
Total	**170**	**246**	**248**	**278**	**417**	**310**

Gender

	2002	2001	2000	1999	1998	1997
Female	40	53	41	49	74	44
Male	130	193	207	229	343	266
Total	**170**	**246**	**248**	**278**	**417**	**310**

Age Groups

	2002	2001	2000	1999	1998	1997
20 and Under	5	7	7	10	12	6
21 to 30	39	52	38	49	73	61
31 to 40	56	97	101	111	173	141
41 to 50	56	65	73	82	122	81
51 to 60	12	19	28	24	35	17
Over 60	2	6	1	2	2	4
Total	**170**	**246**	**248**	**278**	**417**	**310**

INQUEST STATISTICS (2002)

Classification of Death

Natural	5
Accident	5
Suicide	1
Homicide	0
Undetermined	0

Type of Death

Police Custody/Lockup	
Federal Correctional Facility	1
Police Cell Lock-up	6
Police Custody	3
Air Transportation	1
TOTAL	11
Total # of Days	**33**

These 11 inquests resulted in a total of 34 recommendations, addressing a variety of issues. Included here is a summary of these inquests as well as the recommendations made and the responses provided by the relevant agencies. These inquest descriptions are categorized by the type of death.

Correctional Facility - Federal

Case 1 of 1

On April 29, 2002, an inquest was held in Prince Rupert, BC, into the death of a 46-year-old male who died on December 7th, 2000, due to a presumed drowning.

The decedent had been arrested and charged for numerous offenses and a breach of conditions. The judge hearing his bail request ordered the decedent to be remanded in custody, and he was subsequently transported by air to a facility that could hold him until his next court appearance. During transport, the decedent lunged for the exit door of the aircraft and, despite efforts by the deputy sheriff to hold him in the aircraft, he managed to escape.

At inquest, the pilot of the plane indicated that the calls he made to Prince Rupert Flight Services ground control received no response. It was also revealed at inquest that there was a discrepancy between the arresting officers' documentation of the precautionary particulars of the decedent and the deputy sheriff's recollection of there being only a violence coding and no suicide coding in the decedent's file. According to the deputy sheriff, this was why the decedent was treated with only routine procedures. At the time of the incident, there was no policy in the relevant RCMP detachment to provide the sheriff with a copy of the RCMP document that indicates coding entries. There was no such national policy, although it was found to be common practice throughout the province.

The jury found that the death resulted from presumed drowning as a consequence of a witnessed fall from a high altitude into the open sea (note that at the time of

inquest, the decedent's body had not been discovered) and classified the death as a suicide.

Recommendations:

There were a total of five recommendations made at this inquest. The recommendations made to the Inspector of OIC Contract Policing included the following:

- That the RCMP document indicating the precautionary particulars of prisoners be given to the sheriff escort(s) prior to taking custody of the prisoner;
- It was also recommended that the file of the decedent be reviewed by a qualified independent medical professional to determine if there is any information contained in it that may have been overlooked regarding his mental state that could add to the knowledge base and help prevent similar future occurrences.

The recommendations made to both the Inspector of OIC Contract Policing and the Minister of Attorney General included:

- The need for the relevant agencies to collaborate on the meaning and interpretation of precautionary codes to ensure a clear exchange of information;
- The need to consider training prisoner escorts in assessing a prisoner's mental state;
- And the need to secure the transport of prisoners in small aircrafts by ensuring that the transport always be done by charter flight, that there be no fewer than two escorts, and that there be no other passengers on board during transport.

Responses to the recommendations:

The Minister of Attorney General's responses to the recommendations were as follows:

- Regarding the recommendation for the agencies to collaborate for a clear exchange of information, the Minister concurred fully;
- With respect to the recommendation to train prisoner escorts, the Minister emphasized in his response that sheriffs do not have medical training and are not in a position to provide an assessment of a prisoner's mental state, but that perhaps mental state awareness information ought to be provided to sheriffs in order for them to better recognize some of the outward signs of depression in prisoners;
- Finally, with respect to the need to secure the transport of prisoners, this recommendation was not fully implemented as further investigation revealed that using two deputy sheriffs for all small aircraft air escorts would not result in measurable increased security or safety. Since the incident, the Court Services Branch has instituted a mandatory escort security (risk) assessment process for all prisoner escorts, a practice that was to continue following the inquest.

Police Cell Lock-Up

Case 1 of 6

On October 17, 2002, an inquest was held into the death of a 45-year-old male who died on March 29th, 2002, due to acute mixed drug toxicity.

The decedent in this case had a history of mental illness and addiction. On the evening of his death, he had been found to be highly intoxicated in public and was thus arrested and detained in the police cell reserved for intoxicated persons. Approximately 4 hours after being escorted to this cell, the attending guard noticed that the decedent had not moved. Upon physically checking the cell, the guard discovered that the decedent had stopped breathing. Resuscitation efforts initiated by him and continued by paramedics upon their arrival were unsuccessful.

The jury found that the death resulted from acute mixed drug toxicity and classified the death as accidental.

Recommendations:

There were a total of two recommendations made by the jury at this inquest. These recommendations were as follows:

- The recommendation made to the Chilliwack RCMP detachment indicated the

need to consider the introduction of a policy requiring guards to request RCMP officers to conduct a physical check of any inmate found to not have moved for a period of 30 minutes;

- The recommendation made to the Fraser Health Authority indicated the need to consider advising clients with mental health problems being treated with medication to wear a bracelet or carry an identification card to alert others of this.

Response to the recommendations:

The responses to these recommendations were mixed. More specifically, the responses indicated the following:

- With respect to the RCMP recommendation, the response indicated that the policy was incorporated directly into the procedures of the Detachment;
- The recommendation from the Fraser Health Authority indicated that compliance would likely be low, and the cost would be too high for many of the clients. The Health Authority concludes by stating that they do, however, generally support the existing voluntary programs that use medical alert bracelets and those community pharmacies that provide prescription drug profiles.

Case 2 of 6

On November 12th, 2002, an inquest was held in Victoria, BC, into the death of a 44-year-old male who died on June 3rd, 2002, from acute bilateral suppurative bronchopneumonia.

The decedent was picked up by police in response to a call from a high school staff member regarding two men lying on a public road. They were found to be intoxicated. Out of concern for their safety, they were arrested for being in a state of intoxication in a public place and they were transported to police cells. At the time when the decedent and his friend were to be released, six and one half hours after entering the cell, the decedent was found to be unconscious and breathing on the floor of the cell. He was transported to hospital by paramedics and it was determined at hospital that he had a blood alcohol level of .40%. A computed tomography head scan revealed a large right subdural hematoma, and it was determined that he was too neurologically deteriorated for surgical intervention.

Post-mortem examination revealed contusions and intracerebral hematoma, injuries that are most consistent with falling over backwards and striking the head. The injury was estimated to have occurred anywhere from 1 hour before admission to hospital to 2 days before arrest. In reviewing the videotapes taken while the decedent was in custody, it was found by the pathologist that the noted incidents would not have been sufficient to cause such serious injuries.

The jury found that the death resulted from acute bilateral suppurative bronchopneumonia due to acute subdural hematoma associated with a burst right frontal lobe as well as blunt force craniocerebral trauma and classified the death as accidental.

Recommendations:

There were a total of five recommendations made at this inquest. The recommendations made to the Chief of Police of the Victoria Police Department were as follows:

- That there was a need for more training of jailers;
- That there was a need to review the Jail Policy Manual with staff to ensure compliance with existing policies or to amend the manual to reflect a revised acceptable standard;
- That there was a need to record the times when prisoner checks occur;
- And, that there was a need to keep the Prisoner Record Sheet consistent with the Prisoner Medical Information Form.

The recommendation made to the Minister of Health revolved around the need to expand the level of

services offered for the care of persons suffering from alcohol abuse in Victoria.

Responses to the recommendations:

The Victoria Police Department's responses to the recommendations were as follows:

- Regarding the training needs, the Chief of Police stated that the Justice Institute of BC was going to be contacted to conduct an audit to ensure that essential Course Training Standards were being met;
- Regarding the policy, the response indicated that it had been reviewed and several minor changes had been made to ensure that it reflected the practical reality while not relaxing the guidelines in such a way that the prisoner checks would contradict the recommendations made subsequent to previous inquests;
- Regarding the recording of prisoner checks, it was indicated in the response that the detachment would begin to use a new Records Management System that has a Prisoner Booking Sheet Module to automatically stamp time specific entries;
- Finally, the recommendation to make the Prisoner Record Sheet consistent with the Prisoner Medical Information Form was not pursued as it was found that filling out the Prisoner Record Sheet with new information each time would result in losing information recorded in previous booking sheets.

The response from the Ministry of Health Services indicated that the responsibility for the delivery of addiction services was transferred to the health authorities. As such, the recommendation was forwarded to the Vancouver Island Health Authority.

Case 3 of 6

On November 12th, 2002, an inquest was held in Nelson, BC, into the death of a 57-year-old male who died on February 1st, 2002, due to cardiac and respiratory arrest.

The decedent was being held in a custody cell in Nelson, BC, and was awaiting transfer to Kamloops. While in custody, he began to show symptoms of alcohol withdrawal and was thus taken to hospital for assessment, where he was prescribed medication and discharged back to the jail cells. Officers were advised that the decedent's symptoms would likely worsen and that he was to be returned to hospital if he had any vomiting or hematuria. He continued to have symptoms of alcohol withdrawal and he was being constantly observed while in his cell. Despite this constant surveillance, he fell and struck his head on the cement bunk. The response of the police was immediate: a call was placed to paramedics, who transported the decedent to the emergency department where it was determined that he had suffered a severe head injury with considerable blood loss. After stabilization, he was transferred to Kelowna General Hospital for neurological intervention. However, upon arrival, it was determined that there was no intervention that would save his life.

The jury found the death resulted from cardiac and respiratory arrest due to cerebral coning and acute bilateral subdural hematoma, and classified the death as accidental.

Recommendations:

There were a total of three recommendations made at this inquest. These recommendations were as follows:

- The recommendation made to Interior Health, West Kootenay Service Area, revolved around assessment, treatment, and intervention at the hospital from the time of the initial assessment to his fatal fall. This recommendation focused on the need to develop a protocol that provides a consistent process with documentation for medical intervention related to persons who are or become medically unwell while in police custody;

• The recommendation made to the Nelson City Police included issues related to the training of all personnel in the use and checking of the video surveillance-recording device used to monitor the activities in the jail cells.

Responses to the recommendations:

The responses to the recommendations were as follows:

• The response of Interior Health indicated that such a documentation protocol has been developed;

• The response of the Nelson City Police Department indicated that a monitor and recorder that are separate from the main system were implemented immediately to record the activities of high-risk prisoners, and that all personnel were trained in the use of this equipment;

• The police response also indicated that a Prisoner Medical Record form to accompany the prisoner for medical treatment had been drafted. This form provided for comment from the Officer in Charge and any attending Medical Practitioner.

Case 4 of 6

On November 25th, 2002, an inquest was held in Prince George, BC, into the death of a 64-year-old male who died on November 9th, 2001.

The paramedics responded to a call of a fallen male who, upon their arrival, was found to be medically fit with a noted abrasion on his forehead. Due to concerns about his level of intoxication and his safety, the police were called and the decedent was transported to a private cell in the police detachment, where he was later found on the floor. Paramedics attended the cell, bandaged the head injury, and then transported the decedent to hospital, where the laceration was stitched up. A CT Scan was ordered and it was shown that there was an intraparenchymal posterior cerebellar bleed and arrangements were made to transport him to Vancouver General Hospital, where he subsequently died.

Post-mortem examination revealed the presence of hypertension. While it was not possible to determine definitively whether the fall was a result of the intracerebellar hemorrhage or whether the fall contributed to this hemorrhage, it was of the opinion of the forensic pathologist that the former was true and that it was unlikely that medical intervention would have changed the outcome.

The jury found that the death occurred as a result of intracerebellar hemorrhage and classified the death as natural.

There were no recommendations made.

Case 5 of 6

On December 4th, 2002, an inquest was held in Port Alberni, BC, into the death of a 54-year-old male who died on October 26th, 2001, due to asphyxiation.

The decedent had been taken into custody by RCMP officers following an altercation with a taxi driver in front of his home. He was found to be in a state of intoxication in a public place. Over three hours after being booked into cells at the police detachment, where he was monitored by video surveillance, a physical check was conducted and the decedent was found to be unresponsive. As there is no policy at the detachment regarding commencing resuscitation if a prisoner is found in distress, resuscitation efforts were not initiated and an ambulance was summoned. Upon arrival, the attending EHS personnel found the decedent to be exhibiting no respirations or pulse. Nonetheless, resuscitation efforts were commenced and he was transported to hospital. Resuscitation efforts made in the emergency department included the suctioning of a significant amount of material from the decedent's lungs. Post-mortem examination revealed the presence of pre-existing inflammation of the esophagus which led to a series of medical events, including the inhalation of a significant amount of gastric contents into the lungs that was so significant that suctioning would have been insufficient.

The jury found that the death was due to asphyxiation due to massive peripheral inhalation of gastric contents and classified the death as natural.

Recommendations:

There were a total of three recommendations made at this inquest, which were as follows:

- The recommendations made to the RCMP revolved around ensuring that RCMP officers and guards have a current CPR First Aid ticket and that, if already mandatory, that this policy be strongly enforced;
- The recommendation was also made to change RCMP policy and procedures so as to ensure that CPR be administered to any inmate in custody who exhibits no pulse or respirations and be continued until the arrival of qualified paramedics;
- Finally, it was recommended that the RCMP video surveillance equipment be of the highest quality so as to ensure that an adequate assessment of an inmate's well-being can be made.

Response to the recommendations:

The following responses were provided for these recommendations:

- The RCMP indicated that CPR certification is already a requirement that is actively pursued;
- The recommendation to require CPR to be administered was not supported by the RCMP as such a removal of individualized assessment in determining appropriate medical response is an administrative prohibition;
- Finally, the recommendation regarding the quality of surveillance equipment was addressed.

Case 6 of 6

On December 9th, 2002, an inquest was held in Langley, BC, into the death of a 47-year-old male who died on March 22nd, 2002, due to acute combined chloral hydrate, codeine, cocaine, and methamphetamine intoxication.

The decedent had a history of drug and alcohol use. He had several previous encounters with police and was incarcerated on a number of occasions. He was also on a variety of prescription medications. On the morning of his death, he had gone to his doctor with minor injuries, stating that he had been beaten up and his medications were stolen from him and as such, he was re-prescribed his medications. That evening, police responded to a domestic disturbance, where the decedent was found to be very intoxicated and physically restraining his partner. Upon arrest, the decision was made by the responding officers to transport him to the detachment and to have an ambulance called to assess him there. At arrival, he was placed in a holding cell. Upon arrival of paramedics, the decedent had no pulse or respiration. He was assisted with his ventilation and was transferred to Langley Memorial Hospital, where he was later pronounced dead.

Post-mortem examination revealed a lethal level of chloral hydrate in his system, a level within the lethal range of codeine, as well as cocaine, benzoylecgonine, methamphetamine, and alcohol. At inquest, it was revealed that, according to a member of the ambulance crew, advanced level first responders that are trained to do airway intubation and administer cardiac drugs were not available in Langley and that had such a crew been in attendance, emergency physician protocol would have been initiated on site immediately.

The jury found the death was due to acute combined chloral hydrate, codeine, and methamphetamine intoxication and classified the death as accidental.

Recommendations:

There were two recommendations made at this inquest. These recommendations are as follows:

- The recommendation made to the Minister of Health Services indicated that Emergency Health Services available in Langley be upgraded to make available Advanced Life Support Services;
- The recommendation made to the RCMP revolved around the need for a review of its policy of

handling prisoners who are in apparent need of medical care.

Responses to the recommendations:

The responses to these recommendations were as follows:

- The Ministry of Health Services indicated that there is a required call volume level necessary to maintain a high level of knowledge and skills and that development of the Advanced Life Support programs had occurred in those centres which have the population demographics most applicable to their formation and to the continued skill maintenance of these programs;
- Furthermore, the BC Ambulance Service indicated that while the resources are not available to expand the programs to every community, including Langley, its intention was to make these services more available throughout the province;
- Finally, the RCMP response indicated that policies on handling prisoners who are in apparent need of medical care were reviewed and that changes were made to ensure that RCMP members seek immediate medical aid for prisoners, and also to ensure that prisoners in need be examined by a physician.

Police Custody

Case 1 of 3

On March 14, 2002, an inquest was held in Revelstoke, BC, into the death of a 64-year-old male who died on May 11th, 2001, due to sudden cardiac arrest.

The decedent had been pulled over by the Revelstoke Highway Patrol because of the lack of seatbelt usage by himself and the passenger. Upon questioning, it was determined by the police constable that he had reasonable and probable grounds to suspect that the decedent may have been drug impaired. With some resistance, the decedent exited the vehicle. While conversing with the passenger of the vehicle at the side of the road, the decedent suddenly collapsed. Efforts were made by the police constables to resuscitate. The attending BC Ambulance Service (BCAS) personnel, upon arrival, confirmed that the decedent had died at the scene.

The jury found that the death resulted from sudden cardiac arrest due to atherosclerotic heart disease and classified the death as natural.

There were no recommendations made.

Case 2 of 3

On October 28, 2002, an inquest was held in Invermere, BC, into the death of a 40-year-old male who died on April 17th, 2002, due to cardiorespiratory failure.

In the weeks before his death, the decedent's mental health started to deteriorate and attempts made by his wife to schedule a timely appointment with a doctor were unsuccessful. Prior to being able to see a doctor, the decedent entered into an acute psychotic state during which time he made a suicidal gesture. This prompted Emergency Services and the police to become involved and he was taken to hospital, where arrangements were made to take him to a psychiatric hospital in Cranbrook. It was decided at this time that it would be best that the decedent travel by private vehicle. When the decedent was en route at highway speed to the hospital with his wife and a family friend, he exited the vehicle but did not sustain major injuries. Upon arrival of the police, the decedent was restrained and he arrested shortly thereafter. Efforts made by the paramedics and attending physicians and medical staff at the hospital were unsuccessful. At inquest, concern was articulated about the lack of psychiatrists and mental health patients in the East Kootenays.

The jury found the death resulted from cardiorespiratory failure due to hypermetabolic delirium and classified the death as natural.

Recommendations:

There were a total of five recommendations made at this inquest. These recommendations were as follows:

- The recommendation made to the relevant medical clinics and hospitals emphasized the need for all medical clinics/offices to establish emergency procedure which will ensure timely call back by the family doctor or the doctor on call in order to determine the timelines for consultation and treatment;
- The recommendation made to the Interior Health Authority and Emergency Health Services emphasized the need for all hospitals and medical facilities to establish a transport protocol to ensure safe transport of mentally ill patients;
- The recommendations made to the Minister of Health emphasized the need to ensure that rural areas have adequate human resources, such as psychiatrists, psychiatric nurses, home care providers and counsellors, as well as adequate community based programs;
- Finally, the recommendation made to the RCMP, the Interior Health Authority, Emergency Health Services, and the College of Physicians and Surgeons emphasized the need for a third party to evaluate the level of training of RCMP, general practitioners, and emergency services to ensure an adequate understanding and response related to mental health issues.

Responses to the recommendations:

The responses to these recommendations were as follows:

- The responses from the RCMP indicated that training sessions have been developed in consultation with the Canadian Mental Health Association and has been provided to all members of the RCMP;
- The responses from the BCAS indicated that while they were unable to establish transport protocols for hospitals and medical facilities, they were willing to consult with any hospital or medical facility developing protocols with respect to the transportation of patients, including patients with psychiatric disorders;
- With respect to the recommendation to evaluate the level of training of emergency services, the Ministry of Health responded by stating that the BCAS devotes considerable resources to ensuring that paramedics are highly trained and aware of current best practices for responding to psychiatric emergencies;
- The responses of the Minister of Health regarding the recommendations to ensure adequate human resources and community-based programs indicated that the Ministry was continuing to work on the issue of accessibility and service delivery for persons with mental and/or substance use disorders, and on making the system more client-centered. They also indicated in their response that efforts were underway to redesign mental health and addictions services in the Interior Region, to develop tele-health sites in the province to link rural and remote communities with primary mental health sites, and to expand education and consultation to clinicians. Finally, the Ministry indicated that they were developing a resource handbook for first responders and allied professionals who come in contact with offenders with mental disorders.

Case 3 of 3

On December 16, 2002, an inquest was held in Burnaby, BC, into the death of a 34-year-old male who died on January 1st, 2002, of cocaine associated agitated delirium.

The decedent had been picked up by police in response to complaints of a male behaving in a bizarre manner in a local shopping mall. He had attempted to throw himself through a glass window, and paramedics were called to assist. Once he was freed from the window, he was handcuffed and placed in the recovery position when he suddenly became short of breath. The handcuffs were removed but CPR was not initiated by the attending officers as there was no protective face mask available for responders to give mouth-to-mouth and shards of glass appeared to be embedded in his face.

Upon arrival of the paramedics, resuscitative efforts were commenced, but the decedent was found to be asystole and did not respond to all efforts made. At inquest, it was revealed that the decedent had a long history of drug addiction, that he had significant levels of cocaine, morphine and methadone in his system at the time of his death, and that while he was on the Methadone Program, it was not improving his quality of life and he was likely not a suitable patient for such a program.

The jury found that the death resulted from cocaine associated agitated delirium with a contributory factor of acute combined heroin and methadone intoxication and classified the death as natural.

Recommendations:

There were two recommendations made to the College of Physicians and Surgeons of BC, which were as follows:

- To increase the level of training for physicians who administer methadone to patients in their care;
- And, also, to subject physicians prescribing privileges for methadone to more frequent standardized audits to ensure quality control.

Response to the recommendations:

The responses to these recommendations were as follows:

- The College of Physicians and Surgeons emphasized that BC is the only province where every prescriber of methadone has to have attended one methadone workshop during the first year of their authorization, and where a mechanism of audit of methadone prescribing practices indeed exists;
- The response also emphasized that the decedent in this case in fact died of an agitated delirium secondary to the cocaine use and that methadone would have had no impact upon this patient's cocaine use, nor was it a causatory agent in his death;
- Finally, while the College felt that the Methadone Program may require more funding, more education and training of treating physicians, and more oversight, they indicated in their response that they did not feel that this should be an increased responsibility for them.

Air Transportation

Case 1 of 1

On March 4, 2002, an inquest was held in Invermere, BC, into the death of a 65-year-old male who died on June 25th, 2001, from exsanguination and hypothermia.

The decedent was the pilot of a glider that departed the Invermere Airport. Shortly after his return was reported to be overdue, a charter helicopter located and attended the crash site; however, transporting the injured pilot was not possible at that time due to sudden weather changes and the positioning of the glider. The next morning, rescue teams returned and extracted the pilot to load him into the helicopter, at which time he suffered a cardiac arrest. Resuscitation efforts were commenced en route to a regional hospital, where he was pronounced dead.

The jury found the death resulted from exsanguination and hypothermia due to blunt force trauma from a rapid deceleration injury and classified the death as accidental.

Recommendations:

There were a total of seven recommendations made at this inquest. Below is a summary of these recommendations:

- Recommendations made to Transport Canada, the National Soaring Association, and the National Gliding Association revolved around the need to ensure that pilots are checking in regularly and are able to effectively communicate by radio or cell phone, and that all fixed wing gliders have electronic locator transmitters (ELTs);

• Recommendations made to the RCMP, the Provincial Emergency Program (PEP) and the BC Ambulance Service (BCAS) revolved around the need to improve communication and co-operation between emergency groups and personnel through training and meetings, and the need for the better utilization of local resources;
• The recommendation made to the PEP revolved around the need for local members to have pagers for more effective response times;
• The recommendation made to the RCMP and the BCAS revolved around the need to have a mutual emergency radio channel for use by emergency response groups only.

Responses to the recommendations:

The responses from the RCMP were as follows:
• Meetings and a training program were set up with regard to land and air incident plans and a new Commander position was developed for the local Search and Rescue group. This group initiated a new paging system which included all detachment members;
• With respect to the use of resources, the RCMP indicated that, considering the totality of circumstances as known to the relevant detachment Commander at the time, resources were used appropriately and in a manner which possibly prevented further loss of life;
• Finally, with respect to the common radio frequency throughout the province, this recommendation was deemed to be ideal in theory but not in practice due to the prevalence of simultaneous emergencies, which require a suite of frequencies, and also due to the differences in individual mandates.

The responses from PEP were as follows:
• A formal review of the response was conducted and all agencies were brought together to discuss what worked well and to develop recommendations to further improve responses;
• In response to the recommendation to better utilize local resources, PEP indicated that there were no delays in approving the search and rescue response;
• The local search and rescue volunteer team obtained a paging system, which was set to be functional within a short time from the time at which the response was made.

The responses from Transport Canada were as follows:
• Transport Canada emphasized that there are indeed regulatory requirements for flight plans;
• They felt that it was unclear how a requirement for regular check-in intervals (every 2 hours) would have affected this flight as the flight took place outside of airspace requiring radio communications;
• Lastly, they responded to the ELT requirement recommendation by stating that they already advised that ELTs be used when operating over areas of rugged inhospitable terrain, and that in this case, one was used voluntarily. Therefore, according to Transport Canada, to make it a requirement would not have changed the outcome of this case. As such, no action was planned here.

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